Agenda Item 5.b
9/19/07 Meeting

AB 2 (Dymally)
As Amended September 7, 2007

Insurers in all markets must either sell individual coverage on a guaranteed issuance basis with community rating (no health, age, family size or geographic variation) or elect to pay a fee to help finance the high risk pool.

Plans must make their election annually and notify the Board by February 1 of each year, beginning in 2008.

MRMIP

- Eligibility:
  - Continues current eligibility criterion under which an applicant is eligible if declined or "rated up" by one individual market carrier eligible.
  - As of 1/1/09, individuals newly eligible for conversion or HIPAA coverage must obtain that coverage through MRMIP and are eligible for MRMIP. Individuals currently enrolled in conversion or HIPAA coverage may elect to opt into MRMIP or remain in private market coverage.
  - From 1/1/09 until 12/31/09, individuals enrolled in GIP coverage on or after July 1, 2008 are eligible for MRMIP without showing a declination. As of 1/1/09, the bill eliminates the current 12-month "lock-out" for individuals who disenrolled from GIP coverage. All individuals disenrolled from MRMIP pursuant to the GIP 36-month limit on MRMIP eligibility may re-enrolled in MRMIP, if eligible, without reference to the 12-month lock-out.

- Benefits:
  - Effective 1/1/08, MRMIP coverage:
    - May not have annual benefit limit.
    - Must have at least a $1 million lifetime benefit.
    - Must have out-of-pocket maximums of no more than $2,500 per person and $4,000 per family in aggregate deductible and co-payment costs (no change from current law).
    - Must encompass benefits and co-payments, out-of-pocket costs and deductibles appropriate for medically uninsurable and high-risk persons (determined by the Board) compatible with comprehensive products in the individual market, at minimum equal to coverage by health plans licensed by the DMHC plus prescription drug coverage.
    - Must include lower subscriber cost-sharing for primary and preventive health services, and for medication to treat chronic health conditions.
    - Is no longer subject to an explicit statutory limit on the deductibles the board may include. (Current limit is $500/family.)

- Effective 1/1/09, MRMIP coverage must include a six-month pre-existing condition exclusion. (Under current law, board has discretion to impose a pre-existing condition exclusion up to six months but in fact uses a three-month exclusion.)

- Subscriber Premiums: Subscriber premiums would be reduced over time as follows:

  - Effective 1/1/08, no more than 125% of comparable coverage in the private market. Eliminates current 137.5% of market for high loss ratio plans.
  - Effective 1/1/09, 120% of market for subscribers above 300% of federal poverty level (FPL), 110% of market for subscribers at or below 300% FPL.

- Subsidy Financing: The bill

  - Expresses the Legislature's intention to fund the program fully, without having to establish a waiting list, by 1/1/09, from a combination of public and private sources.
  - As of 1/1/09, deletes provisions of existing law that require the Board to administer the program within the limits of the state appropriation for subsidy funds.
  - Maintains the $40 million in Proposition 99 funds as an ongoing source of subsidy funds.
  - Provides for financing of MRMIP costs through carrier fees.
    - Carriers (licensed health insurers or Knox-Keene health care service plans) pay a fee based on a their relative number of "covered lives." Covered lives include all lives in a carrier's book of business, whether insured or administered. "Covered lives" excludes lives in specialized products such as dental and vision, Medicare supplement, etc. as well as CalPERS and public programs. Carriers begin paying fees 1/1/09.
    - The Board is to calculate program costs and the level of fees to be paid by carriers who have elected to pay the fee. Program costs include providing benefits for all prospective enrollees as well as administrative costs and a prudent reserve.
    - The Board is authorized to adjust the fee if program costs exceed projected costs, with a maximum per-covered-life fee of $1.50.
    - Carriers make their "play" or "pay" election annually and notify the Board by February 1 of each year, beginning in 2008. The Board notifies the regulators which carriers have chosen to pay and the amount of the fee owed.
    - By March of each year, beginning in 2008, carriers report information on their covered lives to MRMIB.
    - The regulators, the Department of Insurance and the Department of Managed Health Care, will collect the fees. The regulators are to send the funds to MRMIB within 30 days of receipt. Carriers may remit owed amounts on a quarterly basis.
    - By June of each year, MRMIB must produce a report showing the share of the program's cost for each health plan and insurer.

Return of GIP Enrollees

- The bill continues the current sunset of 1/1/08 for the GIP program, but maintains GIP coverage for existing GIP enrollees until 1/1/09

- By January 1, 2009 those persons enrolled in the guaranteed issue pilot program (GIP) on or after 7/1/08 are eligible to transfer back to the MRMIP program without proving they were declined for other coverage. Others disenrolled through the GIP but not enrolled in GIP coverage on or after 7/1/08 must show they were declined or rated-up but are not subject to the current 12-month lock-out for individuals disenrolling from GIP coverage.

- To assist in this transition, MRMIB and carriers are required to notify all persons who have been or will be disenrolled from the GIP that they maybe eligible to reenroll in MRMIP.

Advisory Committee to MRMIB

- MRMIB is to appoint an 8-member (unpaid) advisory committee to advise the Board on the following subjects:
  - Policies, regulations and operations related to the carrier fee.
  - MRMIP's budget and the appropriate amount for the carrier fee. This includes any adjustments the Board may make to the fee if program costs exceed estimates.
  - Recommendations to improve the quality and cost effectiveness of program operations.
  - The standardized questionnaire that MRMIB is to develop.
  - The types of information MRMIB will collect from carriers so that MRMIB can discern how to allocate fees based on covered lives.

- Committee composition would be:
  - Four plan and insurer representatives, including at least one each that is a payer (not providing coverage to individuals);
  - Two representatives of medically uninsurable consumers;
  - One physician and surgeon;
  - One representative of the business community, and;
  - Ex-officio (non-voting) members: the two regulators or their designees.

- The committee will meet quarterly, unless the Chair decides that a meeting is not needed.

- The committee is to submit recommendations to the Board in writing and the Board is to consider them at its next meeting. If the Board rejects a recommendation, it must communicate to the committee in writing.

MRMIB Report to the Legislature:

By July 1, 2011, MRMIB must report to the Legislature on the implementation of the new law.

- The report is to include information on the number and type of people in the program, program costs and revenues, average per capita and annual increases in subscribers' costs, the later compared with the individual market.
- It is also to include an implementation and transition plan for an alternate approach to providing quality coverage for high risk persons.
- Options to be considered include a reinsurance mechanism or risk-adjustment, or both.
- The transition plan is to presume a change to the new system by January 1, 2012.
- The plan is to include estimated costs and expected fees per covered life.